Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004171	A. BUILDING: _____ B. WING _____	05/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	**11700 N MERIDIAN ST CARMEL, IN 46032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State hospital complaint. Complaint #: IN00116753 Unsubstantiated; lack of sufficient evidence. Facility Number: 004171 Survey Date: 5-6-2013 Surveyor: Deborah Franco, RN Public Health Nurse Surveyor Indiana University Health Hospital North was found to be in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.6-8, Surgical services, Hospital Licensure Rules. QA: claughlin 05/23/13	S 000		